STATE OF CALIFORNIA

Vision Care Plan Disclosure Statement
and
Evidence of Coverage

Contract Number 12020000

PLAN ADMINISTRATOR:

DEPARTMENT OF PERSONNEL ADMINISTRATION
Benefits Division
1515 "S" Street, North Bldg., Suite 400
Sacramento, California 95814

PROVIDED BY:

VSP®

3333 Quality Drive, Rancho Cordova, CA 95670
800-877-7195
vsp.com

T.D.D. for the hearing impaired:
800-428-4833

VSP is an Equal Opportunity and Affirmative Action employer

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FOREWORD

The State-sponsored vision benefit provides vision care coverage for eligible employees and their eligible dependents. Your vision benefit is being provided by VSP under its Regional Network Plan.

The information contained in this booklet constitutes only a summary of your vision benefit and should not be construed as a substitute for the terms and conditions contained in the contract between the State of California, Department of Personnel Administration and VSP.

NOTES

USUAL AND CUSTOMARY FEES - Fees for services and eyewear that are charged by VSP network doctors to their private (non-VSP) patients.

VSP NETWORK DOCTOR - An optometrist or ophthalmologist who has signed an agreement with VSP to provide services to VSP patients.

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ELIGIBILITY

Employees: Eligible employees are defined as: State employees that are (1) permanent employees appointed/working half-time or more who are designated represented rank and file, managerial, supervisory, confidential, and all other eligible employees excluded from collective bargaining, Constitutional Officers, employees of the Judicial Counsel, and Supreme, Appellate, and Superior Court Judges; (2) limited-term employees or TAU appointees whose vision coverage continues based on prior continuous permanent status; (3) permanent-intermittent employees who work a minimum of 480 hours in each six-month control period ending June 30th or December 31st and (4) seasonal employees in Bargaining Units 7 and 8; an employee appointed halftime or more to a temporary appointment in lieu of a permanent appointment, and a limited term employee who is halftime or more with an appointment of six months or more.

Represented employees in Bargaining Unit 6 have vision coverage through their union trust fund and are not eligible to enroll in the State's Vision Program.

Contact your personnel office for additional information regarding eligibility. Conditions of eligibility are subject to collective bargaining.

Dependents: Eligible dependents include the employee's spouse, registered domestic partner or any unmarried child under 23 years of age. An unmarried child includes an employee's: (1) natural or adopted child; (2) a stepchild or child living in a parent/child relationship who is economically dependent upon the employee or a child placed for adoption.

An unmarried child may continue to be eligible as a dependent, beyond age 23, if he/she is incapable of self-sustaining employment due to mental incapacity or physical disability. Medical proof of such incapacity and dependency must be provided to VSP within

DIOPTER - A unit of measurement used to designate the refractive power of a lens or optical system.

ELIGIBLE DEPENDENT - A dependent of an eligible employee who is eligible to be enrolled in accordance with the conditions of eligibility as generally outlined in this booklet.

ELIGIBLE EMPLOYEE - An employee who is eligible to enroll in accordance with the conditions of eligibility as generally outlined in this booklet.

EYEWEAR - Lenses, frame, low vision aides, contact lenses.

GROUP - "Group" refers to the State of California which contracts with VSP on behalf of its employees.

ORTHOPTICS - The teaching and training process for the improvement of visual perception and coordination of the two eyes for efficient and comfortable binocular vision.

OVERSIZE LENSES - Larger than standard lens blank to accommodate prescriptions.

PHOTOCHROMIC LENSES - Lenses which change color with intensity of sunlight.

PLANO LENSES - Lenses which have no refractive power.

PROFESSIONAL SERVICE - Exam, eyewear selection, fitting of glasses, related adjustments, etc.

REGIONAL NETWORK PLAN - VSP's plan under which your vision coverage is provided. Commonly referred to as "RNP".

TINTED LENSES - Lenses which have additional substance added to produce constant tint (e.g., pink, green, gray, blue, etc.).

or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The departmental also has a toll-free telephone number **(1-888-HMO-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's Internet Web site **http://www.hmohelp.ca.gov** has complaint forms, IMR application forms and instructions online.

LIABILITY IN EVENT OF NON-PAYMENT

In the event VSP fails to pay the VSP network doctor, you shall not be liable to the provider for any sums owed by VSP other than those not covered by your vision benefit.

TERMS AND CANCELLATION

This contract shall be effective January 1, 2006 through December 31, 2007.

If service is being rendered to you as of the termination date of this coverage, such service shall be continued to completion, but in no event beyond six (6) months after the termination date of the contract.

VSP reserves the right to reject any and all claims for services or benefits which are filed with it more than one hundred eighty (180) days after completion of services.

DEFINITIONS

BLENDED LENSES - Bifocals which do not have a visible dividing line.

CLAIM - A benefit form submitted to VSP by a VSP network doctor for payment of services or submission of paid receipts by a covered employee/dependent who has received services from an non-VSP provider.

COATED LENSES - A lens with substance added to one or both surfaces.

31 days of continued coverage and may be requested annually thereafter.

ENROLLMENT/EFFECTIVE DATE

Enrollment into the vision plan for most eligible employees and their eligible dependents is automatic. Permanent-Intermittent employees who meet the eligibility requirements must complete a Vision Plan Enrollment Authorization (STD. 700).

Your coverage will be effective the first of the month following the pay period in which your earning statement shows an employer contribution. Contact your personnel office for additional information regarding your enrollment and/or effective date of coverage.

MONTHLY PREMIUM AND COPAYMENTS

The State is responsible for payment of the monthly premium to VSP. You and your eligible dependents will be required to pay a $10 copay to the provider at the time of your eye exam. If eyewear (frames and/or lenses) are provided, you will also be required to pay a $25 copay at the time the eyewear is ordered.

Any additional care, service, and/or eyewear not covered by this plan may be arranged between you and the provider.

PROCEDURE FOR USING THE PLAN

1. **Select a VSP network doctor.** If you need help locating one, phone VSP at 1-800-877-7195 or access the VSP website at vsp.com.
2. **Call your VSP network doctor for an appointment and identify yourself as a VSP member.** Simply provide your name and date of birth as well as the covered member's Social Security number and the organization that provides the coverage (The State of California).
3. **Your doctor and VSP handle the rest.** Your doctor will contact VSP to verify your eligibility and plan coverage. If you are not eligible at the time, the doctor will communicate this to you. If you are eligible, you'll need to pay any applicable

copays at the time of your visit. The copays are $10 for your eye exam and an additional $25 if the provider prescribes lenses and/or a frame. VSP will pay the doctor directly for covered services. **Selecting a VSP network doctor assures direct payment to the doctor and guarantees quality services and eyewear.**

PLAN AND SERVICE FREQUENCIES

Exam	Once every calendar year
Lenses	Once every calendar year
Frames	Once every calendar year

SUMMARY OF BENEFITS

1. **Vision Exam:** You are entitled to a comprehensive exam, including a complete analysis of the eyes and related structures to determine the presence of vision problems or other abnormalities.
2. **Lenses:** The VSP network doctor will order the proper lenses necessary for your visual welfare. The provider shall verify the accuracy of the finished lenses.
3. **Frames:** A frame allowance of up to $75 will be provided by the VSP plan. The frame benefit provides you a choice to select a frame that fits your lifestyle. Therefore, if you choose a frame that exceeds the plan allowance, you will pay the difference. The VSP network doctor will assist in the selection of frames, properly fit and adjust the frames and provide subsequent adjustments to maintain comfort and efficiency. VSP network doctors are required to maintain a selection of frames that are fully covered under your VSP plan.
4. **Contact Lenses:** Elective Contact Lenses: An allowance of $110 will be provided by the VSP plan toward the costs of an exam, contact lens fitting and evaluation costs and eyewear. This allowance will be in lieu of all benefits including exam and

COMPLAINTS AND GRIEVANCES

If you have a complaint or grievance regarding VSP service or claim payment, you may communicate your complaint or grievance to VSP by using a complaint form which may be obtained by calling the VSP Member Services Department's number at 1-800-877-7195 Monday through Friday, 6:00 a.m. - 6:00 p.m. Pacific Standard Time. The completed form should be sent to the address shown on the front of this booklet.

VSP shall acknowledge receipt of your grievance within five (5) calendar days of receipt by VSP. VSP shall also provide a written response to your grievances as required by VSP's licensing statute, the Knox-Keene Health Care Service Plan Act of 1975, as amended. There shall be no discrimination against a member on the basis of filing a complaint or grievance.

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **(800) 877-7195** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proprosed service

4. Replacement or repair of lost or broken lenses or frames prior to being eligible for services
5. Medical or surgical treatment of the eyes
6. Services or eyewear covered under Worker's Compensation
7. Eye exams required as a condition of employment
8. Services or eyewear provided by any other group benefit vision care program

CONTINUATION OF BENEFITS

The VSP coverage is not available on an individual basis, unless you are eligible for continuation of group coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA). Individuals who lose coverage due to certain "qualifying events" are entitled to elect continued coverage. Payment for continuation of vision coverage through COBRA will be paid by the enrollee and mailed directly to VSP. Contact your personnel office for specific qualifying events and the premium you will be required to pay for continuation of your vision coverage with VSP through COBRA.

CLAIMS APPEAL PROCEDURE

VSP shall notify you in writing if a claim is denied in whole or part, of the reason or reasons for the denial. Within one hundred eighty (180) days after receipt of such notice, you may make a written or verbal request for review of such denial, by addressing such request to VSP, whose address and phone number is shown on the front of this booklet.

VSP will review the claim and give you the opportunity to review pertinent documents, submit any statements, documents or written arguments in support of the claim, and appear personally to present materials or arguments. The determination of VSP, including specific reasons for the decision, shall be provided and communicated to you in writing within thirty (30) days after receipt of a request for review.

eyewear. You are responsible for any costs exceeding this allowance.

Medically Necessary Contact Lenses: Medically necessary contact lenses may be prescribed by a VSP network doctor for certain conditions. **A VSP network doctor must receive prior approval from VSP for medically necessary contact lenses.** When the VSP network doctor receives prior approval for such cases, they are fully covered by VSP and are in lieu of all benefits for that eligibility period.

5. **Low Vision - Limitations:** The Low Vision benefit provides special aid for people who have severe visual problems that are not correctable with regular lenses. The treatment plan and charges must be approved by VSP prior to services being rendered. VSP network doctors have the forms to submit for approval. The covered person is required to pay 25% of the cost of any approved Low Vision services. This benefit has a maximum of $1,000 (excluding copayments) every two years. Maximum includes supplementary testing.

   Low Vision benefits obtained from a non-VSP provider will be subject to the same limitations described above. The covered person will be required to pay the non-VSP provider in full and will be reimbursed in accordance with what VSP would pay a VSP network doctor for this benefit. VSP cannot guarantee the reimbursed amount will be within the 25% copayment required when services are obtained from a non-VSP provider.

DUAL COVERAGE

Eligible married State employees may cover each other under this plan. This option does not apply to dependent children.

Please contact VSP for specific information regarding coordination of benefits if you have other vision coverage through VSP.

PROVISIONS FOR VSP NETWORK DOCTORS

If you elect to receive vision care services from one of the VSP network doctors, covered services as described herein, are provided with no additional out-of-pocket cost after any applicable copays. Additional services selected for cosmetic purposes will be the responsibility of the patient. Selecting a VSP network doctor assures direct payment to the doctor and a guarantee of quality services.

PROVISIONS FOR NON-VSP PROVIDERS

If you elect to receive vision care services from a non-VSP provider, you will be reimbursed according to a reimbursement schedule. You must pay the non-VSP provider for all services and eyewear received at the time of your appointment.

FILING A CLAIM FOR NON-VSP PROVIDER SERVICES

To file a claim, you must send your itemized statement of charges to VSP. To be reimbursed, submit your claim within 6 months of the date of service to the following address:

VSP
P.O. Box 997105
Sacramento, CA 95899-7105

VSP will reimburse you in accordance with the following reimbursement schedule. There is no assurance that the reimbursement schedule will be sufficient to pay for the exam or eyewear and VSP cannot guarantee patient satisfaction.

NON-VSP PROVIDER REIMBURSEMENT SCHEDULE

Availability of services under the reimbursement schedule is subject to the same time limits and copays as those described for VSP network doctor services. Services obtained from a non-VSP provider are in lieu of obtaining services from a VSP network doctor. Reimbursement benefits are not assignable.

PROFESSIONAL SERVICES

Vision Exam, up to $35

EYEWEAR

Single Vision Lenses, up to $25
Lined Bifocal Lenses, up to $40
Lined Trifocal Lenses, up to $50
Lenticular Lenses, up to $100
Frame, up to $40
Tint Allowance $5

CONTACT LENSES*

Necessary, up to $250
Elective, up to $110

* Determination of “necessary” versus “elective” contact lenses under the non-VSP reimbursement schedule will be consistent with VSP network doctor services. Reimbursement for contact lenses is in lieu of all benefits, including exam and eyewear services.

EXCLUSIONS AND LIMITATIONS

Your vision plan is designed to cover visual needs rather than cosmetic eyewear. If you select any of the following extras, the plan will pay the basic cost of the allowed lenses and you will be required to pay any additional costs associated with these extras:

1. Blended lenses
2. Contact lenses (except as noted on page 6)
3. Oversize lenses
4. Progressive multifocal lenses
5. Coated or laminated lenses
6. A frame that costs more than the plan allowance
7. UV protected lenses
8. Other optional cosmetic processes

The following services or eyewear are excluded under your plan:

1. Orthoptics or vision training and any associated supplemental testing
2. Plano lenses
3. Two pairs of glasses in lieu of bifocals